THE CRITICAL TIME INTERVENTION

TRAINING MANUAL

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I. THE CRITICAL TIME INTERVENTION

A. Introduction

The Critical Time Intervention (CTI) was designed to prevent homelessness among people suffering from severe mental illness. For these individuals, the transition from institutional to community living is an extremely vulnerable period during which increased support is vital. At present, there is a shortage of mental health programs for homeless people, whether they are residing in shelters, the street, or the criminal justice system. Those that do exist, like inpatient units, often fail to provide continuity of care once the patient moves into housing. The lack of support during this crucial period often results in recurrent homelessness. CTI aims to redress this problem by providing a specialized intervention for this critical transitional period, designed to bridge the gap between services for the homeless and community services. The model is specifically designed to complement rather than to parallel the existing service system for mentally ill people in the community, so that services are not duplicated. (See p. 26-29 for a description of how to start a CTI program.)

CTI is a time-limited intervention, lasting nine months. The phases of CTI, Transition to Community, Try-Out, and Transfer of Care, are each roughly three months. In the Transition to Community phase, the client and CTI case manager formulate a treatment plan, focusing on selected areas identified as crucial in facilitating the client's stability and community assimilation. These might include: psychiatric treatment and medication management, money management, substance abuse treatment, housing crisis management, and family interventions. The main task of this phase is for clients to become linked to appropriate community resources. The second phase, Try-Out, is devoted to testing and adjusting the systems of support that have been established in the community. In this phase, the CTI case manager can make a thorough *in vivo* needs assessment; since the basics should already be in place, she[1] can observe where there are holes in the system, and where the client needs more or less support and services. In the final phase, Transfer of Care, any necessary fine-tunings are made in the network of support. Long-term, community-based linkages should be established and functioning smoothly; the client, CTI case manager, and other key treatment providers should meet to go over transfer-of-care issues and long-term goals.

B. Description of Target Population

People with mental illness and a history of homelessness are one of the most difficult to treat and poorly served clinical populations (Levine & Rog, 1990). They have multiple impairments (Bachrach, 1984; Drake et al., 1989) which include a lack of basic subsistence needs, poor social supports, and untreated

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[1] For convenience, we will refer to all case managers as "she" and all clients as "he".

psychiatric symptoms. They also have very high rates of physical illnesses and general health problems (Breakey et al., 1989). According to Brickner (1992), the homeless bear the largest burden of untreated illness in the United States. Given these characteristics, they have many concrete needs that any intervention must be prepared to address.

Bachrach (1993) has defined modern day homelessness as an absence of stable housing in a context of disaffiliation from social supports and resources that are normally available through the mainstream culture. CTI is designed to facilitate affiliation with social supports and community resources for people who have moved from a shelter, the streets, a psychiatric hospital, or the criminal justice system to the community. The CTI case manager, then, is a mediator between the client's concerns and what the social system can offer. For example, a CTI case manager will take into account a client's vulnerabilities, skills, resources, and motivation, and consider the community resources available given each particular client needs and desires The community's housing options, vocational rehabilitation possibilities, employment, and social services can all be considered according to how appropriate they would be for the client. The CTI case manager tries to ensure that this matching will be a two-way street-- both the client and the community's resources are invited to adapt to each other. This is in contrast to many situations the client has likely encountered before, where he has been asked to conform to his environment, as in cases of involuntary hospitalizations.

The CTI model assumes that individual client characteristics, which can be improved through the intervention, such as a commitment to mental health care, or good money management skills, have an impact on the client's ability to retain housing. CTI also recognizes, however, that structural factors, such as the declining availability of low-cost housing, labor market changes, and cuts in income are major reasons for increased homelessness in this population (Koegel, 1995). The homeless mentally ill, then, are the least able to compete for low-cost housing in this shortage situation.

C. The Original CTI Study

The effectiveness of CTI as compared to usual services only (USO) was examined in a randomized clinical trial between 1990 and 1994. The site of the study was the Columbia-Presbyterian Psychiatry Shelter Program in the Fort Washington Armory Shelter for men in New York City. Men in the CTI group received services tailored to their needs for the nine-month period of transition into community housing, through a continuous relationship with a CTI case manager, whereas men in the USO group received existing community services. Given that the 1990 New York/New York agreement created many supportive services and housing facilities for the homeless mentally ill, many of the men in both CTI and USO groups had access to high-quality community services. The main outcome measure analyzed was the number of nights homeless each man experienced during the 18-month follow-up period. Clients in the

CTI group had significantly fewer homeless nights than the control group, an average of 30 days as compared to 91 in the USO group (Susser et al., 1997).

II. THEORETICAL BACKGROUND AND FORERUNNERS OF CTI TREATMENT MODEL

A. Continuity of Care

Bachrach (1981) defines continuity of care as "...a process involving the orderly, uninterrupted movement of patients among diverse elements of the service delivery system" (p.1449). For the homeless mentally ill, with their multiple impairments and service needs, this is especially difficult to insure. A problem also exists on a structural level: The mental health establishment has failed to assess adequately the complexities of deinstitutionalization, which caused care to be dispersed, while once it had been housed under one roof (Bachrach, 1981). Although community mental health centers were intended to fill this void, they failed in their mission, as they were effective only for clients who were comfortable seeking out care in mainstream, office-based settings (Torrey, 1986). This failure, resulting in high rehospitalization rates, and the migration of released patients to public shelters, has been widely documented (Freedman & Moran, 1984; Lamb, 1984).

Bachrach (1981) details the elements comprising continuity of care: it is *longitudinal*, meaning that the clients' treatment parallels their progress, even though individual caregivers, specific treatment modalities, or specific sites may change; it is *individual*, meaning that care is planned with the client, addressing his particular needs; it is *comprehensive*, meaning that clients can receive a variety of services related to their many needs; it is *flexible*, meaning that clients are allowed to progress at their own pace, and are not held to the standard of continually moving forward; it is organized around *relationships*, meaning clients' contacts with the service system are characterized by familiarity and closeness; it is *accessible*, meaning that clients are able to reach the service system when they need it, and in a way which is psychologically and financially manageable; and, finally, it is characterized by *communication*, both between the client and service providers, and among the various service providers involved with the client's care. In sum, continuity of care stresses the importance of clients' connectedness to reliable caregivers, that persists over time. These elements, Bachrach points out, strongly imply the need for someone to coordinate and insure this continuity of care. This person is typically a case manager.

B. The Case Management Model

Case management makes continuity of care possible. Although definitions of case management vary widely, most would agree that it consists of some combination of linking, which involves connecting clients to available resources, and direct clinical care. Case management focuses on treating the individual and his or her environment. This occurs both through the clinical relationship, and through the case manager's

intervening in the client's external world, in order to create a more responsive care environment (Swayze, 1990). The corresponding goals are improve the client's quality of life, through reducing symptomatology, focusing on rehabilitative goals, and identifying and providing reasonable living situations so as to prevent the cycle of recurrent homelessness (Swayze, 1990). The case management relationship, then, assists the client both practically and emotionally. Several studies have demonstrated case management's efficacy (Goering et al., 1988).

C. Early Applications of Community Treatment Models

By the late 1970s, case management was recognized as a vital component of support services for deinstitutionalized psychiatric patients (Turner & TenHoor, 1978). More recently, these services were also demonstrated to be effective with homeless mentally ill people (Belcher, 1988; Lamb & Lamb, 1990; Swayze, 1992). In 1978, New York State developed a Community Support System (CSS) program to provide case management services to people suffering from chronic mental illnesses (Curtis et al., 1992). The Training in Community Living (TCL) program (Stein & Test, 1980) was also implemented at this time. This program was pioneered to meet the need for continuity of care, and also aimed to reduce the rates of rehospitalization for those discharged from psychiatric facilities. It stressed the following ideas: material resources needed to be secured for these clients, coping skills had to be taught in order to facilitate adjustment to community life, and care had to be delivered assertively. In other words, once staff saw that clients were decompensating, they were to offer treatment assertively, rather than passively waiting for clients to seek help (Olfson, 1990). Results of a study of the model showed that rehospitalizations were greatly reduced over the course of 14 months, and clients were better adjusted in their communities than those in the control group (Stein & Test, 1980). However, once the special programming was discontinued, many of these gains were lost. The study authors surmised, then, that this type of case management program needed to be ongoing to be effective in the long-term.

D. Assertive Community Treatment

Assertive community treatment (ACT) models are the current day incarnations of the TCL program. A summary of experimental evidence on ACT programs concluded that it was successful in reducing hospital utilization in the chronically mentally ill; however, results did not show that it was more effective than conventional treatment in controlling symptoms, promoting social functioning, or improving occupational functioning (Olfson, 1990). Morse and colleagues (1992) showed that ACT services were also effective in reducing nights homeless in those who had a history of homelessness. One important and consistent finding in the ACT literature is that clients prefer community-based treatments to traditional hospital-based care (Olfson, 1990). A study by Dixon and colleagues (1993) emphasizes that success in ACT programs is also related to compliance with treatment recommendations; without this element, interventions become less effective. The ACT model is endorsed by the National Alliance for the

Mentally Ill (NAMI); family members like the security of knowing their relatives will be monitored and not allowed to slip through the cracks.

These interventions are all forerunners of CTI, which incorporates many of the key features of these programs. CTI is structured to insure the principles of continuity of care that Bachrach outlines. Like other case management models, it also focuses on linking clients to available resources, and intervening in the client's environment to create a more responsive care system. It also provides direct care where and when needed, for a time-limited period. This is a major difference between CTI and ACT models; CTI is not a long-term approach. Rather, CTI facilitates long-term care's delivery in the community. The CTI approach also assesses clients along a continuum. On one end, there are clients who can do little on their own, and need many direct-care services; on the other end are clients who are fully able to care for themselves. The CTI approach recognizes that people fall out along this continuum, and may even move back and forth along the poles at different points in their lives. CTI case managers work with their clients to determine where on the continuum they fall, and what level of services they need as a result. CTI strives to help the client live in the least restrictive environment possible, but with an appropriate level of support. The nine-month intervention period allows a trial time when clients can move along the continuum, and settle at a point that is the closest possible fit to their needs and desires. CTI also sets up a situation where if the client needs to move in either direction, people in the community involved with him will either strengthen the safety net, or allow that client to increase his independence, as the situation warrants.

III. AREAS OF INTERVENTION

A. Introduction

Several areas have been identified as crucial in facilitating clients' stability, community assimilation, and the prevention of the cycle of homelessness. These five areas, psychiatric treatment and medication management, money management, substance abuse treatment, housing crisis management and prevention, and family interventions, should be addressed and monitored in every stage of CTI. One or two should become the primary focus, depending on the individual client. Some may not be applicable; not all clients have contact with family, for example, or substance abuse problems.

These areas are by no means the only ones that may addressed by the CTI case manager and client during the nine-month period; additional foci, such as vocational training and other life skills, can be added according to each client's individual needs. For example, education, vocational training, or life skills training might be areas to focus on where appropriate.

The following describes in detail why each of the five main areas have been identified as crucial to CTI's success:

B. Psychiatric Treatment and Medication Management

Establishing psychiatric services in the community is an integral part of a successful transition to community living (Lamb, 1992; Susser et al., 1992). The CTI case manager facilitates this link between the client and the new psychiatric provider, and serves as a resource for both parties. The CTI case manager can be a resource to clients by accompanying them to the first few appointments, by talking to them about how comfortable they feel with their new provider, and by trying to make other arrangements if the match seems poor. The CTI case manager can also be a resource to the new provider, giving insight into the client's particular strengths and vulnerabilities, and supplying information about psychiatric and medical history. In addition, CTI case managers have a role to play in providing direct services to clients. This is particularly true in the first phase of the CTI intervention, when clients may refuse treatment, or when there are delays in access to community services.

Clients may be hooked up with different modalities of mental health care, depending on their desires and the particular problems they are working on. Since all clients in the CTI target group have a mental illness, all will need a psychiatrist or nurse practitioner as one of the providers of services. In addition to this, many clients will have other providers; for example, clients and CTI case managers might recognize the benefits of cognitive-behavioral, interpersonal, group, family, or supportive psychotherapy, as well as long-term case managers, such as work with an intensive case manager (ICM) and ACT teams. Since the CTI model recognizes the importance of both formal and informal mental health supports, a range of community providers may be enlisted in addition to traditional services, including self-help groups, clubhouses, peer counselors, and family members.

Medication compliance is a crucial part of ongoing psychiatric treatment. The CTI case manager attempts to establish a system in which the client can easily obtain medications, and be encouraged to take them. Psychoeducation is usually an important component of adherence to the medication regimen; discussions of the rationale for taking medication should be carried out by the CTI case manager with the psychiatrist, the family, and residential staff, where appropriate. Addressing side effects and other factors that might interfere with a client's medication compliance is crucial. The CTI case manager might also role-play with the client ways of talking to his psychiatrist about these medication issues. Whenever possible, a medication monitoring system should also be set up. Self-monitoring could be done by the client, perhaps by using a pill box, putting the week's medication into small envelopes for daily use, or creating a chart. If the client is not able to self-monitor, an arrangement could be made at his residence to have someone monitor his pill intake until he is able to do it independently.

C. Money Management

Successful money management is another crucial component in a client's adaptation to community living. The rent must be paid. The CTI case manager works with the client to budget money accordingly, and monitors the client's success in this endeavor. When the individual is not able to effectively master this skill, alternative arrangements are made; for example, a payee can be designated, who can then give the client money in increments. Independent money management always remains the ultimate goal, which the client can perhaps reach after more practice budgeting.

CTI case managers will also aid their clients in maintaining entitlements. Ideally, any benefits the client is entitled to will be applied for before the client moves into the community. However, additional work is often needed before everything is in place, and CTI case managers can play a role in helping clients collect supporting documentation to secure or maintain their entitlements. Often entitlements are cut off for bureaucratic reasons, in which case the CTI case manager may need to go with the client to the welfare or social security office, to help them fix whatever problems arise. Clients will also learn where these offices are, and will have contact numbers for the case workers handling their benefits. In this way, they will be able to advocate for themselves if problems arise after the intervention period.

Special attention must be paid to money management when the client has a history of substance abuse. In these cases, a realistic plan to pay the rent should be devised from the outset. In the first CTI stage, Transition to Community, the CTI case manager can perform this function; in the second and final stages, community people, such as a family member or a landlord, should be enlisted to help. Where appropriate, payments can be made directly to the client's residence.

D. Substance Abuse Treatment

Substance abuse problems are very serious and potentially undermining of CTI's effectiveness. The original CTI study showed that the intervention was less effective with those with serious substance abuse problems. Studies have also shown that clients who are dually diagnosed have poorer mental health outcomes than those with only a mental illness (Drake et al., 1989). For these reasons, it is imperative that CTI targets this problem. Since CTI is time-limited, the most practical approach is to try to facilitate the client's commitment to change harmful addictive behaviors.

CTI approaches substance abuse both through an intervention during the nine-month period, and through a careful analysis of the client's long-term needs, and the supports they will necessitate well beyond the intervention period. The CTI model uses the following principles outlined in the substance abuse literature: treatment intensity, stages of change, motivational interventions, and harm reduction (Carey, 1996). We

will discuss how these principles can be adapted to the unique situations of people who have a mental illness and have been homeless.

1. CTI Substance Abuse Intervention Techniques

Treatment Intensity

The first principle stresses that since drug and alcohol problems vary in magnitude, the intensity of treatment should match the severity of the disorder (Institute of Medicine, 1990). Following from this, the least restrictive options should be explored first; more intensive ones should be employed only when necessary. For example, someone who has been drinking everyday for years will likely need a detoxification, followed by an inpatient rehabilitation, whereas someone who uses marijuana on occasion might be able to do well with outpatient substance abuse counseling.

Stages of Change

Motivational interviewing is informed by Prochaska and DiClemente's Stage Model of the Process of Change (1992), which is a transtheoretical model of how people change addictive behaviors, with or without formal treatment. It is vital for the CTI case manager to identify which stage the client is in; each stage implies a different level of awareness and readiness for change, and different intervention techniques. If techniques are used that do not match the client's level of awareness and commitment, they will be ineffective. If they are appropriate, however, they are an excellent spur to help the client move to the next stage in the change process.

Prochaska and DiClemente's (1992) model contains the following stages: *Precontemplators* are individuals who do not consider their substance abuse to be a problem and are not considering change. *Contemplators* realize that they do have a problem, and are considering the feasibility and costs of changing their behavior. In the *determination* stage, individuals make the decision to take action and change, and make preparations to facilitate this. When they begin to modify their problem behavior, they are in the *action* stage, which lasts about 3-6 months. After successfully navigating this stage, they enter the *maintenance* stage. *Relapse* is also recognized as a stage in this cycle. It is worth emphasizing that relapse is not seen as a treatment failure, but as an inevitable part of the process of recovery.

Again, it is vital for the CTI case manager to understand the stage of change the client is in. If she initiates a discussion of the benefits of AA meetings to her client who is in the precontemplation stage, her recommendation will fall on deaf ears; her client is not yet aware that substance abuse is adversely affecting his life.

Motivational Interviewing

The substance abuse intervention carried out by the CTI case manager is based on motivational interviewing techniques (Miller & Rollnick, 1991). Motivational interviewing is designed to mobilize the client's own desire to change; its techniques are nonconfrontational, and geared to minimize the defensiveness often created by traditional confrontational techniques. Motivational interviewing helps clients move through the stages of change faster and more effectively than they would without intervention. It assumes, however, that the responsibility and capability for change lie within the client.

Motivational interviewing has specific recommendations of how counselors can work most effectively with clients, depending on their stage of change. Miller and Rollnick (1991) recommend the following techniques: In *precontemplation*, raise doubt, and increase the client's perception of risks and problems with current behavior; in *contemplation*, tip the balance, evoke reasons to change, risks of not changing, and strengthen the client's self-efficacy for change of current behavior; in *determination*, help the client to determine the best course of action to take in seeking change; in *action*, help the client take steps toward change; in *maintenance*, help the client to identify and use strategies to prevent relapse; in *relapse*, help the client to renew the processes of *contemplation*, *determination*, and *action*, without losing hope because of the relapse.

CTI has modified the model by only using the interviewing techniques; unlike motivational interviewing, there is no extensive substance abuse assessment battery to give the client feedback about the severity of his use, or the ensuing medical consequences. However, the CTI case manager should take a history of substance use, with a particular focus on frequency, severity, and choice of substances used, how the client views the costs and benefits of continued use, and strategies the client has used in the past, if any, to curb use. CTI case managers should also rely on their clinical skills to monitor what the client is not willing to reveal about their substance use. For example, CTI case managers might be on the lookout for money seeking behavior, the selling of possessions, curfew violations, irritability, or any other significant changes in the client's mental status. In addition, CTI case managers should be on the lookout for physical signs, such as poor hygiene, changes in skin pigmentation, weight less, or burns on fingertips. Triggers for substance use should also be explored; if the client is not aware of any, the case manager might ask for several stories about past use episodes. Together, the client and case manager might be able to identify what feelings or circumstances lead to substance use. This inquiry will help inform the CTI case manager

about the intensity of treatment needed, the stage of change the client is in, "trigger" situations, and strategies that may help the client curb his use.

The motivational interviewing intervention can be carried out throughout all phases of the CTI intervention. Early in the CTI intervention, people are likely to be in the precontemplation stage. If they can be moved along into the contemplation stage by the time they enter housing, this will likely facilitate their being able to retain their housing. We recommend, however, that CTI case managers emphasize motivational interviewing in the beginning of the "Try-Out" phase of the intervention. This allows time for the client and case manager to establish a therapeutic alliance, and allows time for the client to have settled into his new housing. Carrying out motivational interviewing in the middle of the nine-month CTI period also allows about three months for the case manager and client to continue the interviewing if it has not yet inspired change, or get the client involved in long-term treatment if he has decided he wants to change. Whenever possible, a person important to the client should be involved in the interview sessions. This could be a family member, spouse, a friend, or a sponsor from a 12-step group. This significant other can help support the client in his commitment to change well beyond the CTI intervention period.

Motivational interviewing approach is remarkably consonant with the clinical techniques recommended in the CTI model: It seeks to develop the client's own strengths where possible, and lend support where those strengths are not yet present. Motivational interviewing outlines five basic clinical strategies: express empathy, develop discrepancy, avoid argumentation, roll with resistance, and support self-efficacy.

--"Expressing empathy" communicates respect for the client, and avoids inferior/ superior dynamics. It conveys an acceptance of the clients as they are, while also supporting them in the process of change. Freedom of choice and self-direction are respected.

--"Developing discrepancy" refers to the process by which people become aware of a discrepancy between where they are and where they want to be. First, however, clients' awareness must be raised as to the personal costs of their substance use. In other words, clients must be helped to reach the *contemplation* stage by having this discrepancy developed. Often, clients have lost housing in the past because of continued substance use, or are in danger of losing current housing because of continued use; when this is the case, this can be discussed as a cost of substance abuse.

--"Avoiding argumentation" must be practiced even as the case manager tries to develop discrepancy. Strong confrontations about a client's substance abuse often evoke defensiveness and opposition, and makes the client feel that the case manager does not really understand. At the same time, however, CTI case managers may need at certain times to bring up some of the possible negative consequences of continuing to use. Again, loss of housing due to substance abuse, and the perpetuation of homelessness are often relevant issues to be discussed. As long as this is done in an empathic and nonpunitive way, these kinds of discussions may be helpful to the client.

--"Roll with resistance" means the client is encouraged to think about problems in new ways, but the case manager's viewpoint is not imposed. Ambivalence is viewed as an expected part of the change process, and should be explored openly. Clients need to be able to talk about what substances do for them, and their fears of what might happen if they were not to rely on them.
For people with histories of homelessness, substance use is often an important part of social interactions. For this reason, people may fear that if they give up substances they will be unable to connect with other people. The peer-oriented nature of 12-step groups are especially helpful in helping people connect through abstinence rather than through addiction.

--"Support client self-efficacy" is the final stage. "Self-efficacy", a term introduced by Bandura (1982), is the belief that one can perform a particular behavior or accomplish a particular task. In the case of substance abuse, clients must believe that they can change their addictive behavior. Without this hope, there is little chance that they will be willing to try to overcome their powerful addiction.

By using all these techniques, the CTI case manager improves the chances that the client will commit himself to change. If the client has made this commitment, he will be much more likely to use long-term supports after the nine-month CTI period.

Harm Reduction

Harm reduction (Marlatt & Tapert, 1993) is based on the idea that substance use exists on a continuum of abstinence to abuse. If a person reduces the quantity or frequency of substance use, its harm will be reduced. Although abstinence may still be the ultimate goal, any reduction in use is encouraged. This stance is in contrast to traditional all-or-nothing approaches to substance abuse treatment, where clinicians refuse to treat anyone who has not made a commitment to abstinence. An example of this relevant to CTI

might involve a client who is still using substances when he moves into housing in the community. If substance abuse might jeopardize the client's housing, the client and case manager might find a way to minimize this risk. For example, the client might agree not to get high or drink in the residence. Although this is not ideal, it is a realistic first step in helping the client preserve his housing, and move towards sobriety.

2. Long-Term Referrals

The CTI case manager will make referrals informed by her understanding of where the client is in the stages of change, and the intensity of the treatment needed. In the *determination*, *action*, and *maintenance* stages, 12-step groups such as Alcoholics Anonymous, Narcotics Anonymous, Cocaine Anonymous, and Double Trouble groups are excellent resources. Some day treatment programs also have MICA (Mentally Ill, Chemical Abusers) components. MICA residences are also possibilities for clients with long-term substance abuse problems.

In addition to making referrals, the CTI case manager should work with informal community supports, such as family members, educating them about the biology and dynamics of substance abuse, and helping them set appropriate limits and establish strategies to help clients maintain their sobriety.

E. Housing Crisis Management

To avoid housing crises, perhaps the most important preventative measure is the client's desire to live in the residence in which he has been placed. (The word "residence" will be used to refer to any living situation.) Client and environment congruence, conceptualized as the degree to which the client's needs, capacities, and aspirations are consistent with the resources, demands and opportunities of the community living situation, can be a deciding factor in clients' success in retaining housing (Coulton et al., 1984). Clients who are satisfied with their residences will be much more likely to take the steps necessary to make their living situations work.

Crisis situations related to housing involve a range of scenarios, such as threat of eviction, or psychiatric decompensation. The CTI case manager and client should try to foresee potential housing crises, identify ways to avoid them, and coping strategies and resources if they should occur. When facing housing loss, the client will almost certainly need to call on someone to help negotiate the situation with the housing provider. Therefore, in addition to her direct care role, the CTI case manager should help identify

appropriate community resources for the client to call upon if need be. This plan for dealing with housing crises should be one which can be implemented during and beyond the nine-month intervention period.

An example might be a client who steals the TV from the community room to sell on the street to obtain money for drugs. If the client admits what he has done, and is willing to make reparation, he, the CTI case manager, and the housing provider might make an agreement that the client will pay back the money to buy a new TV, and attend MICA groups. Another example might occur with a client who is living with his family, has been acting in a bizarre manner, and has not showered in several weeks. In this situation, the CTI case manager might arrange a meeting with all parties to negotiate a new understanding about what the client must do to continue living with his family; they might agree that the client take his medication in front of someone for the next month, and would shower at least once a week. The entire CTI team can be mobilized in these instances. For example, if the client has not taken medication in several months, the CTI psychiatrist might provide a new prescription, or administer an intramuscular shot. In general, family interventions should be increased when conflicts heat up, and continue as needed after their resolution, to safeguard any new contracts the family members have agreed upon. CTI case managers should also work with clients and their families on skills for crisis resolution, such as how to listen to each other, and how to speak to each other without going on the attack.

F. Life Skills Training

In Vivo Life Skills Training

The fundamental nature of the CTI intervention is to provide support, assessment, treatment, and life skills training in the community. An entire literature exists documenting the merits of social skills training (cite Liberman and others) for individuals with chronic mental illness. Test and Stein (2000) provide a clear recommendation for in vivo skills training in the context of community-based case management. We prefer the more encompassing term "life skills" over social skills, since it encompasses the learning of a range of adaptive behaviors, such as use of transportation, cooking, grooming, as well as how one conducts oneself in a social situation.

As the reader will see from the example below, there are some skills that a formerly homeless person might lack that can be easily overlooked, but might significantly affect his quality of life to the point that

housing might be jeopardized. The example also reflects some points emphasized elsewhere in this manual, such as the importance of overcoming cultural and language barriers.

The following case illustrates the importance of in vivo, or community-based life skills training.

Edwin is a 31-year old Spanish-speaking man who suffers from chronic schizophrenia. After years of living in shelters, several hospitalizations, and intensive on-site treatment in a shelter, he was finally accepted by a supported single room occupancy residence. There he would have his own room with a kitchenette. He had great trepidation over leaving the familiarity of the shelter, but finding him housing run by a program with bilingual staff helped ease the transition. Furthermore, his CTI case manager, Pablo, was fluent in Spanish.

For several months, Edwin expressed a vague dissatisfaction with his new housing and a desire to return to the shelter. He did state that he felt he was paying too much in rent and meals, leaving him incapable of sending money home to his mother. A plan was made with his CTI case manager that involved Edwin cooking his own meals in order to save on some of his expenses. Edwin assured Pablo that he knew how to cook.

On subsequent visits, Pablo insisted on taking Edwin out to lunch, sometimes refusing invitations to eat a meal prepared by Edwin. Pablo believed he would be imposing on Edwin, and knowing Edwin's financial concerns, felt guilty accepting a meal paid for by Edwin. However, one day Edwin insisted that Pablo share a meal prepared by Edwin in his own room. Several critical facts about Edwin's adaptation to his new home were then revealed.

To begin, upon his arrival Pablo buzzed the intercom to Edwin's room, then waited 15 minutes without receiving a response. Pablo was able to find a security guard who led him to Edwin's room. To Pablo's surprise, Edwin was inside, but he did not know how to operate the intercom! Next, they sat down to eat. Edwin had planned to serve chicken, but Pablo discovered that it was still raw. Edwin then revealed that he had never used a microwave before and was under the impression that he could cook a chicken in a matter of seconds.

As Pablo provided instruction and modeling of these skills, Edwin became noticeably more comfortable. He then revealed, still with some embarrassment, that he did not know how to work the window shades and window lock. As a result, his room remained dark and the air stale, dry,

and overheated.

Several points deserve emphasis. First, none of these problems would have been addressed had Pablo not gone to Edwin's room. Secondly, Pablo's feeling of guilt over accepting a meal from Edwin was unwarranted. Certainly, the invitation may have been a way for Edwin to ask for help while "saving face." Edwin's pride, a portion of which is culturally determined, was preventing him from asking for help with tasks that most people take for granted. This, of course, is another key point for the case management team. Take nothing for granted. It must be a routine practice to see how the patient lives and to ask about specific life skills. Contrary to what some people might feel, this helps alleviate stigma, rather than reinforce it. Furthermore, giving a person the opportunity to demonstrate his skills and do something for others, such as preparing a meal, is wonderfully therapeutic. Not only does the individual experience the satisfaction of mastering a task, but the end result is also a shared social experience. A good meal consists not only of the food served, but also of the conversation and company kept.

Lastly, this example illustrates how important the so-called "little things" are in life and how attention to these details could mean the difference between sustained housing and recurrent homelessness. Had Edwin continued to reside in his dark, stuffy apartment, unable to use the microwave and intercom, he would have experienced increasing social isolation, frustration, shame, financial stress, and physical discomfort in his living place. The shelter or streets become attractive alternatives. Simple in vivo assessment and skills training readily remedied these problems.

G. Family Interventions

When appropriate, CTI works with clients' families in order to provide psychoeducation on the nature and treatment of mental illness. This education will facilitate families' ability to respond to crises that might arise after the client's placement in the community. In the first three months of CTI, the CTI case manager will cover the following areas:

1. The Nature of the Critical Time Intervention

The CTI case manager explains the intervention model, and the role of the family in adding to its success. The need for support at the time of transition, the type of services that CTI offers, the different types of residential facilities available, and case manager and family roles in supporting the client are all discussed.

2. The Nature of the Mental Illness

This entails educating the family about typical symptoms of the mental illness, and psychiatric and psychosocial approaches to treatment. Medication education will also be done, to explain what symptoms the medication treats, and common side effects. CTI case managers try to alleviate the guilt and stigma many families feel when a relative has a mental illness. Misconceptions are also clarified if need be-- for example, some family members may believe that their child's drug use has caused his mental illness.

3. Positive and Negative Support

CTI case managers work with families on how to most effectively and sensitively confront issues in order to support the client's residential stability, growth, and independence. The principles we advocate are consistent with those the CTI case manager follows: being supportive, empathic, flexible, consistent, and encouraging of autonomy but available in times of crisis.

Special attention should also be paid to how the family deals with stress. Since clients may be particularly sensitive to stress and conflict, the family may function better if members learn how to communicate clearly, and learn problem-solving skills (Grunebaum & Friedman, 1988). For example, clients will probably be most receptive to positive comments made in a calm, supportive tone, and requests made simply and directly (McFarlane & Cunningham, 1996).

Case managers can also gather valuable information from the family about how to most effectively support the client. For example, families can give history about what has worked and what has failed in the past.

After these psychoeducational sessions have been completed, CTI case managers will remain available to mediate between clients and their families for the remainder of the CTI period. Common situations where the CTI intervention can be beneficial are: mediating substance abuse related conflicts, where the client may demand money or resort to petty thievery; facilitating communication between family and staff at community residences; and giving general counseling, where CTI case managers can talk with families

about their feelings about the client. CTI case managers can also help families learn to set clear boundaries and limits, and educate them about the importance of having a clear and consistent way of interacting with the client.

IV. CLINICAL PRINCIPLES OF CTI

A. Assessment of Concrete Needs and Linking

In each of the three stages, the CTI case manager will need to assess the client's concrete needs. During the course of recovery, the needs of a person with severe mental illness will change. This is especially true for the individual who makes the transition from homelessness to housing. In this context, we refer to "needs" in three spheres: Housing, treatment, and psychosocial rehabilitation (e.g., vocational, educational, and social needs). Careful evaluation of the needs of people with severe mental illness is vital for successful community living (Ford et al., 1992).

For the period of treatment during which a mentally ill individual is homeless, needs assessment is an ever-changing, evolving process. Progress alternates with setbacks and the goal is for an overall trend towards housing readiness. There are times when a careful needs assessment is especially important: during the initial contacts (outreach), at the point of entry into treatment (engagement), and when the client becomes ready to find housing.

Our work in a shelter setting has been described elsewhere (Kass et al., 1992). Here we will focus on the unique opportunity for a community-based needs assessment afforded by CTI.

Frequently, needs assessments and treatment plans are completed when a homeless individual is leaving an institutional setting, such as a hospital, shelter, or criminal justice setting. Often, these plans, if done at all, are narrow in scope or incongruous with the client's realities. Examples include the release of mentally ill jail detainees with nothing more than a referral to a general shelter, or the offering of prescriptions to a discharged hospital patient who has no insurance benefits with which to purchase medications. There are countless examples of such failures during transition from one setting to another. However, even a comprehensive plan at the point of transition from homelessness to housing may become obsolete after several months of residence in the community.

CTI affords clients an opportunity to have their long- and short-term needs assessed once they are established in community-based housing. Since CTI is time-limited, it is particularly important to establish a long-term plan for the client prior to the conclusion of CTI. The needs of the client are evaluated for each of the clinical areas of CTI: psychiatric treatment and medication management, money management, substance abuse management, housing crisis management, and family interventions. The long-term plan should also address additional needs of the client, such as education, vocational training, and social life.

An individual's housing needs and preferences may change over time. Prior to the intervention period, the CTI team should try to match the client with a living situation meeting his needs and desires. Residences vary in their levels of support and services. If the residence the client has chosen does not seem to be a good match for him, adjustments can be made to find a new place for him to live. The CTI case manager will have to evaluate, however, whether there is genuinely a problem in the living situation, or if the client is reacting with anxiety to an unfamiliar and therefore daunting new environment, which is causing him to resist staying there.

We recommend a comprehensive assessment of a client's long-term housing, treatment, and psychosocial needs during the Try-Out phase of CTI (see p. 29-33 for a description of this phase), generally during the 4th-6th months of the intervention. Although these needs can be addressed without using a formal interview, there are a few instruments that we favor for this purpose. These include the Rehabilitation Evaluation (REHAB) (Baker & Hall, 1988), the Denver Acuity Scale (Sherman & Ryan, 1998), and the Level of Care Utilization System (LOCUS) of the American Association of Community Psychiatrists (1997). The use of a standardized needs assessment has the advantage of generating useful outcome data for research and quality assurance. In addition, some measures, such as the LOCUS, provide a measure of progress for an individual client if administered at different times in the course of a client's recovery.

In addition to the five areas of CTI intervention described above, the client and CTI case manager should explore what might give the client a sense of meaning and purpose in his life. Often, people with mental illnesses have talents and abilities that are unrecognized or neglected by themselves and those around them. Employment, vocational rehabilitation, volunteer work, and clubhouses are all possible areas for exploration. If the client and CTI case manager decide that these areas are of interest, but not practical or desirable at the present time, at least some options will have been pinpointed that may instill in the client a sense of hope for the future, and motivation for change.

B. Assessment of Psychological Needs

Different psychological issues come up in each stage of CTI. These psychological issues are often overlooked by practitioners working with the homeless mentally ill, since these individuals' concrete needs and psychiatric symptoms tend to dominate the clinical picture. However, the philosophy of CTI recognizes that these psychological issues are crucial, and must be carefully handled if the intervention is going to be successful. The following description outlines some common psychological issues that may emerge. CTI case managers should be aware of them, and bring them up in CTI team meetings, discuss them with involved community providers, or talk about them directly with the client, as the situation warrants.

First, there are "baseline" psychological issues that must be assessed. Some initial questions the CTI case manager might want to keep in mind are: How much support does the client want? Are CTI case manager's interventions experienced as helpful, or intrusive? Does the client accept suggestions from the case manager, or instead prefer to ignore them, or do the opposite? What is the client's cultural background? How does it affect how the client is able to seek or receive help? Is there a cultural or racial difference between the client and CTI case manager? If so, how will that affect the work they do together? How does the client typically deal with stress? What "natural" support systems are available to the client, such as family or friends? Does the client typically make use of them in times of trouble? Or, when crisis hits, does he isolate himself? What are typical scenarios that have led to the client becoming homeless in the past? The case manager should try to evaluate all these questions from multiple viewpoints: from discussions with the client, observations of the client's behaviors, consideration of life and treatment history, and conversations with others involved in the client's life, such as family, friends, or treatment providers.

Most people struggle with opposing wishes when they seek help. On the one hand, they may wish to be dependent, taken care of, and relieved of responsibility; on the other hand, they may wish to maintain a sense autonomy, independence, and self-esteem (Mann, 1973). This struggle may be particularly intense in homeless mentally ill people, since, because of their psychiatric problems and concrete needs, they have had to either be very dependent, relying on others for their care or sustenance, or have been out on the streets alone, fending for themselves. Some clients may wish to feel supported and cared for, but will experience case managers' attempts to do so as compromising their autonomy and freedom. Many of

these clients have had aversive past experiences in the mental health system, and are loathe to open themselves to further contact (Susser et al., 1992). Living on the street also erodes self-esteem, so maintaining personal pride and self-determination becomes extremely important. One psychiatrist wrote, "For such individuals, lack of insight into their deficits may belie keen insight that disclosing or acknowledging such deficits either threatens autonomy or increases vulnerability" (Kuhlman, 1994, p.100). Given the social adaptations one may make as a mentally ill person living on the street, as well as individual feelings about nurturance and autonomy, each client must be observed to see how these issues manifest themselves. When the CTI case manager is sensitive to this dimension of the client's experience, she is able to work more empathetically with him, and is better able to balance being supportive with leaving room for autonomy. Over time, the CTI case manager will try to find the right balance between providing structure and waiting on the sidelines for the client to find his own way. In general, CTI advocates the least coercive approach, so increased client autonomy is always the goal.

C. Assessment of Client's Strengths

All clients have a wealth of strengths and abilities they bring to their situations; these may include job skills, social skills, educational strengths, or creativity. These strengths, however, are often not recognized by clients or by those around them. Clients who have been living in shelters may appear to have little initiative, seem emotionally unresponsive, and act excessively dependent on others. These behaviors, however, may not be intrinsic to the client; they may instead be the remnants of adaptations the client has made to shelter life (Gounis & Susser, 1990; Grunberg & Eagle, 1990). This phenomenon, known as "shelterization", or "institutionalization", often occurs when clients have been in situations where they were unable to exercise their autonomy, and can mask their strengths, skills, and abilities.

We believe that clients can be most effectively engaged when their individuality is recognized and nurtured. Our clinical philosophy also follows this model: Clients are assumed to have the internal resources needed to make positive changes in their lives; however, these resources may have atrophied from disuse, or may need to be adjusted for use in new settings. The CTI case manager's role is to help discover and rehabilitate these strengths. In addition, CTI case managers can regard elements of the client's personality usually seen as bothersome-- such as loudness or constant talking, as a strength, as these characteristics may help the client persevere, and get the attention he needs.

Most homeless mentally ill people have already shown extraordinary ingenuity in being able to survive on the streets. These skills can be examined, and reframed for use in different situations. For example, a client's skill in sizing up potentially helpful or dangerous people on the streets might guide him as he begins new relationships in the community.

D. CTI Case Managers' Therapeutic Stance

In a review of the psychotherapy research literature, Orlinsky and Howard (1978) found that the relationship between the therapist and client was a major determinant of successful treatment outcomes. Although the CTI case manager is not a therapist in the strict sense of the word, we believe that the same ingredients are present in constructing a therapeutic relationship. With this in mind, CTI recommends a few therapeutic guidelines which can foster a positive relationship between the case manager and the client, and are appropriate for a time-limited intervention. We believe that being active and focused, supportive and empathic, consistent but flexible, fostering autonomy while remaining available, and effectively dealing with treatment refusal are crucial techniques in creating a therapeutic alliance, which can lead to better treatment outcomes.

1. Active and Focused

Since CTI is time-limited, CTI case managers must be active and focused to be effective. An active and focused stance will be needed, for example, when the case manager and client do a needs assessment and a treatment plan. When doing these, they should collaborate in how to manage each of the five areas of CTI. The case manager should obtain a commitment from the client to actively work to accomplish points on the plan. If the client disagrees with any of the CTI case manager's suggestions, the issue can be put on the back burner, to be taken up again periodically. In the meantime, an alternative plan to which the client can agree can be devised. Both client and case manager responsibilities and tasks should be clearly outlined, and a time-table for achieving the plan should be made.

2. Supportive and Empathic

Support and empathy are crucial in the formation and maintenance of the therapeutic alliance between client and CTI case manager. When the case manager is empathic about the client's feelings, needs, beliefs and ideas, the client will feel supported. CTI case managers should be especially sensitive to clients' self-esteem. When a person's self-esteem is injured, he is likely to retreat defensively, or act out aggressively towards himself or others. If this happens between a client and CTI case manager, the client

may not be receptive to the case manager's input. Clients may be very sensitive to critical tones, and their feeling criticized will inhibit free expression of concerns, perceived failures, and present conflicts.

Paying attention to certain details will also help the case manager to understand her client:

--Observe the client's non-verbal behavior, such as facial expressions, body movement, posture, physical distance, eye contact, and general appearance. This will yield information both about how receptive the client is to the case manager, and how much psychological distress he is in.

--Listen to the client's verbal statements: choice of words, recurring themes, voice volume and tone, and amount and speed of talking.

--Observe whether non-verbal and verbal expression are discrepant. Does the client say he agrees with the plan, but his speech is clipped, his body averted, and he will not make eye contact with the case manager?

The following techniques can aid in conveying the case manager's support and empathy:

--Reflecting feelings. For example, if the client talks for ten minutes about how his neighbor's loud music kept him awake until 2 a.m., the case manager might say, "Sounds like you are feeling angry at your neighbor." These statements, though simple, can let the client know that the case manager has been listening, and understands something of what the client is going through.

--Clarifying. At times, the client's feelings about a particular situation may not be clear. In this case, it is best for the CTI case manager to ask directly, rather than trying to infer what the client might be feeling. This will not only clear up questions in the case manager's mind, but may also give the client the opportunity to think something through in more detail, thus clarifying for himself how he feels about the issue.

--An awareness of past experiences that might be impacting the client's present beliefs, expectations, and feelings about others. For example, a client may have been abused as a child, and may now believe that others are trying to exploit him. It is helpful for the CTI case manager to keep in mind the way each client

typically experiences the world and perceives others' interactions with him. However, this understanding should be used with discretion; it is usually ineffective and unempathic to dispute a client's perception of a situation. Instead, the CTI case manager might gently suggest some alternative explanations for the same data.

--An awareness of the CTI case manager's own feelings when working with different clients. CTI case managers may notice that they feel very differently towards different clients. For example, a case manager may feel very protective towards one client, and wish to save him from whatever trouble springs up. With another client, she may feel like giving up, believing that the client does not actually want help. These feelings can give the case manager very valuable information about how the client feels about himself, and how he typically interacts with others. This understanding can help the case manager deal with the difficult feelings some clients may engender. For example, if a particular client makes a case manager feel helpless and inept, this might indicate that the client feels these things. The client might also be trying to avoid the experience of being disappointed, and so might try to make the case manager into someone who has nothing to offer anyway. Of course, each situation is unique, and these issues should be talked about in CTI team meetings, where the role of a senior clinical team leader or supervisor will play an essential role. The important thing for the case manager to realize is that her own feelings have an impact on the clinical process, and can bring valuable information to light. For these reasons, they should not be disregarded or considered the case manager's private problem.

Cultural awareness is also a vital component in providing support and empathy. When the CTI case manager and client come from different racial, ethnic, or social class backgrounds, the case manager must be aware of how these differences may be contributing to misunderstandings between the dyad. The CTI case manager might be sensitive to these issues by asking the client how certain issues are looked at within the client's culture. For example, a client who abuses alcohol might be asked about what cultural role it plays for him. The case manager can still work with the client's substance abuse as a problem, but be empathic to the extra layer of difficulty in the client's abstention. In other areas, case managers might deviate from their standard practice to be sensitive to the client's culture. For example, a case manager might accept a gift, knowing that gift-giving is an important way of expressing gratitude in that client's culture.

The following example illustrates how sensitivity to the client's religious and cultural beliefs and practices facilitated the formation of a treatment alliance:

Eduardo is a 45-year-old man who was born and raised in the Dominican Republic. He suffered from chronic paranoid schizophrenia and was always on guard against perceived persecution by others. Living in a shelter was a constant struggle for him. He maintained a tough, sometimes intimidating demeanor to counter the ongoing threats he felt to his sense of himself as a man.

As a believer in Santeria, Eduardo kept several very human appearing dolls he called his "babies." Sometimes he carried the dolls with him, talking to them and grooming them. Sometimes he left the dolls on his shelter bed arranged elaborately with beads, crosses, and other religious items. No one touched Eduardo's "shrine" because they he knew he was "loco."

When first referred to our program, Eduardo did not acknowledge having a psychiatric illness and he refused to take medications. However, he did connect to the program director and several Spanish-speaking staff.

Early in the course of his treatment, Eduardo became very upset when shelter staff asked him to remove the items on his bed, citing a rule against leaving possessions on one's bed. They were concerned that someone might steal the items and set off a fight. In our day treatment program, Eduardo loudly and repeatedly voiced his anger towards the shelter staff who were telling him to remove his things, dolls included.

Although Eduardo's rants could be disruptive and intimidating at times, the staff of the day treatment program understood the significance of his possessions. To Eduardo, the dolls held the spirit of the ocean, the sea, and the rivers. Furthermore, he believed that these spirits derived from the daughters he so rarely got to see. We assured Eduardo that we would take up his cause with the shelter staff and try to persuade them to allow him to keep his possessions on his bed. In doing so, we learned that the shelter did allow religious items to be displayed on one's bed. We explained that the dolls and others items were religious in nature and the shelter staff agreed to let Eduardo keep them undisturbed.

This show of advocacy and cultural sensitivity towards Eduardo reinforced his bond with the program and strengthened his trust in the staff, eventually helping him to accept anti-

psychotic medication. With treatment, Eduardo became much less paranoid and less irritable. He was then able to move, with his "babies" of course, into his own apartment.

3. Flexible but Consistent

To be flexible and consistent may seem like a contradiction, but we believe it can be done. Both clinical stances are very important. Flexibility allows CTI case managers to respond sensitively and practically to a myriad of situations. For example, a feature of the treatment plan designed before the client moved to the community may prove impractical or undesirable when the time comes to put it into action. Flexibility also allows more of a collaboration between client and service provider than is typically offered in the mental health system. Usually, service providers make recommendations, and clients' failure to embrace them are chalked up to "treatment-resistance." In the CTI model, however, the case manager can make a more informed evaluation about what is "resistance" and what is the client's rightly protesting a poor service linkage. For instance, a case manager's trip to a day-treatment program that a client has been refusing to attend might reveal a poor match; the other clients at the program, for example, might be much lower functioning than the client. In other situations where the client's difficulty cannot be attributed to a poor match, the CTI case manager may just have to "roll with resistance" until the client is ready to change.

Flexibility also allows the case manager to respond to the client on an as-needed basis. Studies have revealed (Tanzman, 1993) that clients with mental illnesses prefer this to a more rigid structure. Flexibility is also a companion to *in vivo* needs assessment, which takes into account changing individual needs, and allows for a more realistic appraisal of, and response to, clients' capacities, strengths, and limitations. CTI case managers who are flexible also treat their clients differently depending on each individual's particular constellation of strengths and difficulties.

Consistency is the complement of flexibility. In some situations, the case manager may feel it is not in the client's best interests to change an agreed-upon plan. For example, a client might not want to attend psychiatric appointments. Although the case manager cannot control what the client will do, she would do well to stick to this part of the treatment plan, and try to do psychoeducation with her client.

It is also important for clients to feel that the CTI case manager is consistent as a person-- that she remembers their appointments and arrives for them on time, that she reiterates goals agreed upon in the treatment plan, and that she behaves towards the client in a similar manner over the course of their many meetings.

At times, the CTI case manager may feel she has to choose between being flexible and being consistent. For example, perhaps she and the client have agreed that he will apply for MICA housing if he starts using drugs again. The case manager then learns from staff at the client's residence that he came in high the night before. However, they feel that he has been doing well generally, and are willing to keep him on. The client, also, seems to be adapting very well to his new environment, and says he cannot stand to "start all over again." He says his slip was precipitated by the anniversary of his brother's death, and swears he will not continue to use. What should the CTI case manager recommend? In these tricky situations, the CTI case manager should discuss the situation with the whole CTI team, to weigh the pros and cons of either being consistent, and advocating for MICA housing, or being flexible, and not pushing for other housing, given that the situation seems to suit the client. Whatever decision is made, the case manager should also talk with the client about his feelings about his brother's death, and explore how his substance use might be an attempt to avoid mourning this loss.

4. Fostering Autonomy while Remaining Available.

CTI case managers must try to strike a balance between being responsive and encouraging independence. Again, clients need the ability to move along a continuum of support. At times, the client may need more autonomy in order to grow. At other times, the client may need greater support to maintain psychological or material stability.

These principles are especially important in the second and third stages of CTI, when clients are increasingly caring for themselves, or finding people in the community who can help them where and when they need it.

5. Dealing with Treatment Refusal.

In this section, we present two perspectives on dealing with treatment refusals. The first point of view is that of a consumer and administrator of a consumer-oriented mental health association (JR). The second is that of a psychiatrist and the director of a CTI program (AF).

A Consumer's Perspective

Helping through Trust

People who have mental illness, especially those who are homeless, may have good reasons for refusing services. They may have a history of forced or coerced treatment, which may have done them more harm than good or, at the very least, caused them to feel powerless over their own lives.

The key to overcoming their resistance is for outreach workers to foster the development of trusting and stable relationships between themselves and the individuals they are seeking to engage. I know this from my personal experience as someone with serious mental illness who has also been homeless, as well as from many years of providing support to people in a professional capacity and, finally, running an agency that does so.

When people are afraid of "the system" and are not willing to accept services, it's important not to push it. Any program that is attempting to engage homeless people needs to build in time for a long engagement process, and spend a lot of time building relationships. Outreach workers should keep making offers of help, but shouldn't take it personally if someone refuses, they should simply wait for a while and repeat the offer. It might take three weeks, three months or three years, but people will eventually accept some level of care. People are always more willing to accept something from someone they know than from a stranger. They need the freedom to make that choice when they're ready. The worker has to be willing to go at their pace.

To successfully engage people in services, you have to meet them where they're at—both literally and metaphorically. Successful outreach workers engage people on the street, in the railroad station, under the bridge, wherever they are.

In addition, it is enormously helpful if the workers are people who have "been there"— who have been homeless and/or who have struggled with mental illness and/or drug and alcohol addiction and are in recovery. Peers have a head start in establishing a rapport; it' s easier for people to trust someone who has been through the same experiences. In addition, peer workers seem to have a natural understanding of how to reach out to people as equals. For example, if they encounter someone lying on a grate, peer

outreach workers automatically sit down next to the person. I've rarely seen a professional sit down next to a homeless person on the street, whereas you don't have to teach peer workers to do this; it just comes naturally. (On the other hand, we have outreach workers who don't share that history but are still very effective because they are patient, consistent and caring. They have also learned how to talk with people from observing the more experienced workers.)

Another key factor in engaging people is finding out what they want, rather than trying to give them what you think they need. A good place to start is on a very practical level: food, a cigarette. (However, some people may be too fearful to accept food.)

When people are ready and willing to come in, it is vital to be prepared to give them substantive help. All the services they need should be available for the asking, so when people are ready to choose those services, they can join right in. At the same time, there should be no pressure to do so.

It's also vital not to give up on people. A lot of case management services discharge people because they say they don't want services anymore. If someone who has been accepting services decides they don't want services anymore, bear with them.

As a result of employing these methods, we have seen a lot of people get well who had been labeled unreachable and untreatable. We have seen people who had been on the streets 10 to l5 years get into treatment, stabilize in housing, go through rehab and get jobs, with minimal supports. We have seen people reconnect with family members, get their children back. We have seen people get clean.

One of our clients, a man in his forties who I'll call Arnold, was psychotic and delusional when the outreach workers first engaged him. He had been on the streets for years, and seemed incapable of holding a conversation.

What helped Arnold was that the two outreach workers were out there every night talking to him. They let him know that they had been homeless and had also had mental illness. After a while he started to trust them and began, at their urging, to take his medication. Our program found him a place in a PDR (Progressive Demand Residence) and, when he was ready, he moved to an apartment, operated by another service for homeless people with mental illness, where he has more independence. Arnold now

holds down a job in a restaurant run by the program that manages his residence. We still provide him with case management, and he receives therapy from a third program. He is doing well.

Another client, a woman in her fifties who I'll call Rachel, had also been homeless for a very long time. She has serious mental illness as well as a substance abuse disorder and AIDS. It took almost a year before she was willing to come in. First she lived in a shelter, now she lives in a residence for formerly homeless people that is operated by our agency; three days a week she attends a day program run by another agency. She also does volunteer secretarial work at another one of our programs. She sometimes still uses drugs and panhandles, and her boyfriend is still on the street; our workers continue trying to get him to come in. But she takes her mental health and AIDS medication and keeps her doctors' appointments. Rachel said that one thing that worked for her was that the outreach workers were so caring, and talked with her about improving her life.

As these stories indicate, we measure progress in small steps, and we know that sometimes that means one step forward and two steps back. But we hang in there; and we get results.

A Provider's Perspective

In the course of treating a homeless person with a severe mental illness, clinicians must anticipate some degree of treatment refusal at any point in time. However, the significance of the refusal will vary depending on the individual client and the timing of it. As a general rule, CTI holds that treatment refusal should be viewed as a client's way of communicating something to the clinician, not simply as an act of defiance. The therapeutic stance should be to aim to understand the communication with the client, not to engage in a power struggle. When the CTI case manager is able to put the reasons for treatment refusal into words, the client is less likely to keep expressing the communication through action, in the form of treatment refusal.

Treatment refusal by a homeless person can be understood based on the stage of treatment. We see refusals at the very outset of treatment, in the course of treatment, prior to obtaining housing, at the time of the Transition to the Community phase, during the Try-Out phase, and at the Transfer of Care phase of CTI. Refusals at each of these junctures will be discussed in the "Assessment of psychological issues" section of each of the three phases.

When a new client refuses treatment, the clinician should gently test his willingness to discuss it, realizing that the refusal to accept treatment might preclude any such discussion. In this case, we recommend backing off and reassuring the client of your availability to help when he feels ready. Sometimes it helps to shift the focus from the usual clinical aims (taking a history, doing a mental status exam, making a diagnosis, prescribing treatment) to exploring what the client perceives to be his most immediate needs. This will often provide an opportunity for engagement. Patience and empathy must guide this non-intrusive approach. Of course, the clinician must feel secure that the client is not a danger to himself or others for the approach to be appropriate and effective.

Should a client continue to refuse treatment despite one's best attempts to engage him, it helps to recognize that importance of periodic monitoring and checking in with that client. Staff often needs a reminder that they can still be helpful to the client who refuses services. By observing that client, staff can identify signs of decompensation and provide access to inpatient treatment when needed. Furthermore, periodic outreach to test the waters of the client's willingness to engage in treatment will reassure the client of staff's consistent presence and will allow opportunities for a breakthrough.

Commonly, clients refuse services when first engaged by mental health providers. Again, the case manager should ask, "What is the client telling me?" Is the client having medication side effects? If so, does he feel too embarrassed to discuss them (e.g., sexual impotence), or does he have no faith that anything can be done about them? Any of these possibilities can be addressed once recognized. Other services may be refused for any number of reasons. Some clients do not want to apply for housing out of fear of change. Some refuse vocational services fearing loss of benefits. Some refuse treatment when they relapse on substances or simply become angry with staff for any number of reasons. Being able to recognize the reason is essential for any clinician working with this population.

V. THE THREE PHASES OF CTI

A. Introduction

CTI is sensitive to the changing needs clients have during the nine-month transitional period from institutional to community living. Very different challenges characterize the first months, the middle period, and the termination phase. Therefore, CTI is conceptualized as moving in three distinct phases, each approximately three months long. This is not to say that these phases are completely self-contained;

challenges for the client and tasks for the CTI case manager, though often peaking in a particular stage, are likely to recur throughout the intervention period. The three phases are: Transition to the Community, Try-Out, and Transfer of Care.

B. Phase One: Transition to the Community

1. Assessment of Concrete Needs and Linking

Before the client first moves to community housing, the CTI team formulates a treatment plan with specific attention to the five areas described above as facilitating community stability: psychiatric treatment and medication compliance, money management, substance abuse management, housing crisis management, and family interventions. Special attention is given to factors precipitating housing loss in the past, as well as current needs and difficulties. Since the intervention is time-limited, services must be prioritized; some will need immediate attention, and others can be addressed later.

The main task of this phase is linking clients to appropriate resources, and moving away from providing assertive, direct care. The client will need a psychiatric provider, and may also want to attend a day treatment program or clubhouse. Some clients may want vocational training, and some may want to find work. The CTI case manager should work with the client in determining which options would be most realistic and beneficial. CTI case managers may need to continue to provide direct care as a kind of "safety net" if community resources fail or are not yet in place.

Good linkages are crucial to the success of the intervention; these are the people and agencies that will gradually assume the primary role of supporting the individual in the community. It is essential that the formation of a linkage be a gradual process that it tested and modified as indicated. Previous linkage models have been criticized for passing along the responsibility of providing care without guaranteeing continuity. Assertive Community Treatment (ACT) has been developed, in part, to counter the tendency to pass clients along without anyone taking responsibility for assuring continuous care.

The process of forming linkages from the CTI case manager to community providers can be illustrated by the method for running a relay race. Although there is a delineated area in which the baton must be passed in any relay (the nine-month limit in CTI), the process is best accomplished when the runner receiving the baton gets a running start. The runner passing the baton then must run together with the receiver until the grip on the baton is secure. For a while, both runners share a hold of the baton. This is a

metaphor for the shared responsibility for the client's well-being that especially marks the latter part of the Transition to Community phase of CTI, heading into the Try-Out phase. We will explore the process of evaluating the strength of these linkages in our discussion of the Try-Out phase of CTI.

During the Transition to Community phase, the CTI team has a high level of contact with the client, maintaining regular phone contact, and visiting the new residence to evaluate the client's adjustment to community living. The discharging mental health program continues to provide psychiatric treatment until the CTI case manager is able to link the client with a new provider. The client may not immediately feel comfortable with his new treatment provider, or the new program or agency he is attending. Accompanying clients to appointments with new agencies may help smooth this stressful experience. There is the potential for conflicts to arise as the new providers and the client adjusts to one another. The relationship established between the CTI team and the client prior to community placement guides the CTI case manager as she mediates between the client and the prospective network of support. CTI case managers will also work with clients to strengthen their ability to advocate for themselves. These linking services will taper off as the intervention progresses, with the expectation that the client will eventually be comfortable interacting with his treatment providers on his own.

2. Assessment of Psychological Needs

When a client first leaves a shelter or hospital, or even a jail or a prison, separation issues will arise. Although the client might not have been particularly happy to be living there, he will likely have achieved some level of comfort and familiarity in that environment. In addition, it is likely that he will be leaving behind some important relationships. This is usually difficult for anyone to do, and the situation carries special freight for a person who has been homeless and has a mental illness. Studies have shown that many in this group have a childhood history of out-of-home placement, such as foster care, group home placement, or running away (Susser et al., 1991). Therefore, times of transition and separation may revive these traumatic experiences. CTI, therefore, tries to provide the opportunity for a gradual, empathic separation, so as not to compound the challenges of this already difficult time. This might include encouraging the client to take trips back to the shelter to maintain relationships, or to call the discharging hospital to let the staff know how he is doing. Clients might also want to work as consumer advocates with people still in the shelter, talking with them about the experience of moving into community housing, and inviting them to see their new residences.

CTI case managers will probably need to have a good deal of contact with clients during this period, as their need for support is perhaps at its highest. Case managers may also need to increase contact if the client seems to need it. Increased peer or family contact may also be recommended.

When treatment is refused around the period of the Transition to Community, one must always think of the stress associated with leaving homelessness for community living. Loss of contact with peers and staff might play a role as might living up to new expectations in the community. CTI case managers should be aware that in some cases, clients in this phase may sabotage progress they have made in order to not re-experience distressing separations, and to avoid the vulnerable feelings new relationships can bring. Clients may also have poor self-esteem and feel they are not worthy of good things, and consequently may feel guilty when they are thriving. This sense of unworthiness or guilt may not even be in the client's conscious awareness. The case of "Charles" discussed below (p.27-28) illustrates some of these conflicts. If the client seems to be floundering in the community, these difficulties should be considered as possible causes, and the situation should be addressed with the client and discussed in CTI team meetings. More than anything, managing this "critical time" is what CTI is all about.

3. Assessment of Client's Strengths.

A vital strength that can help the client in this period is the ability to form new relationships. These new relationships, in the residence, community, and with new mental health providers, will become the bedrock of the client's adjustment to his new living situation. It is important, therefore, for the CTI case manager to gauge how easy it is for the client to do this. If this strength is not present, the case manager may need to be a bridge between the client and those with whom he will be forming new relationships.

Another strength that must be assessed in the initial phase is adult daily living (ADL) skills. Can the client cook, clean, do laundry, use public transportation, find his way around the neighborhood? The CTI case manager may need to step in and teach or model these skills when necessary. If possible, however, the CTI case manager should try to mobilize the client's own natural support network. For example, if the client has a brother who cooks well, this brother might be enlisted to give cooking lessons. Or, if the client has a friend living in the community he is entering, that friend might give him a tour, pointing out such things as the grocery store, a pharmacy, bus and subway stations, etc.

Perhaps most importantly, the client will need to be able to ask for advice and support during this difficult initial transitional time. Many issues will come up in this period, and the client may not know how to deal with some new situations. The CTI case manager may have to encourage the client to call her in these situations, if the client seems unlikely to do so naturally.

4. Clinical Example

The following case illustrates common psychological and practical dilemmas that come up for a client during the Transition to Community phase, and how several CTI clinical principles are used to successfully deal with these issues.

Charles is a 37-year-old African-American man who was unfocused, disorganized, dressed bizarrely, and had a delusion that he was an important attorney when he was first contacted by case managers doing outreach in the shelter. Charles had a previous history of psychiatric hospitalization, but had been out of treatment and homeless for many years. Initially, he was unable to acknowledge his need for treatment. However, the program psychiatrist was able to engage him around his delusion of being an attorney. This was accomplished by giving Charles yellow legal pads for him to take notes relating to his delusions. As the relationship between Charles and the program staff developed, the psychiatrist explained to Charles that program property (the yellow pads) had to stay in the program, but Charles was invited to come in and use them there. Over a period of several months, this finally led to Charles trusting the staff enough to accept their recommendation that he take anti-psychotic medication. With this, Charles improved dramatically and was able to move into a supportive SRO residence.

During the Transition to the Community phase of CTI, Charles unexpectedly acted out in ways that jeopardized his housing. He began to associate with a woman who was using crack cocaine. Charles began to show signs that he too was using. Despite encouragement to stay in the residence and receive help, Charles decided to move into the woman's apartment, paying a share of the rent. Recognizing that this was an impending housing crisis, a meeting was arranged with Charles, the staff of the residence, his CTI case manager, and the CTI psychiatrist.

At this meeting, it became clear that Charles was reacting to the stress of the transition to the community by breaking ties to the mental health system and trying to establish his "independence."

On the strength of their ongoing relationship, the CTI staff was able to effectively confront Charles with the fact that he was setting up a fragile and false sense of independence that would surely lead him back to the shelter or to a hospital. It was suggested that Charles might not be aware of it, but he may prefer this to the stresses of forming new attachments in the community.

The CTI staff also anticipated that drug users might come into the apartment and steal his things, that the woman with whom he was living might demand more rent money (he did not have a lease with her), and that he might suffer a relapse under the influence of cocaine. Charles considered all this carefully and was sincerely grateful for the concern, but still decided to stay with the woman.

After the meeting with Charles, the CTI case manager proposed that the residence hold Charles's bed for as long as possible. It was agreed that they would do this for two weeks, but after that time, Charles would have to return to the shelter if he lost the apartment. This was conveyed to Charles. As predicted, before the two weeks passed, Charles's things were stolen from the apartment and the woman with whom he lived was asking for more money. Charles moved back to the residence and, for the past six years, he lived there and in another more independent residence run by same agency.

5. Discussion

A point worth emphasizing about this case is that while the CTI case manager and psychiatrist recognized the danger of Charles's behavior, they also respected his need to make choices and to discover things for himself. Their understanding of his desire for autonomy and independence were conveyed to him in an empathic way, while at the same time they maintained that supportive housing, medication compliance, and abstinence from drugs were in Charles's best interest. Since Charles needed to find his own way, they were flexible enough to allow him the time to do this. It is easy to imagine mental health providers reacting to Charles's subsequent failure with a, "We told you so. You'll have to live with the consequences of your mistake now." Instead, however, the CTI team resisted being punitive towards him, and created a safety net for Charles. The housing providers were flexible too in holding Charles's bed for

him. This combination of flexibility and consistency, so essential to CTI, helped preserve the alliance between Charles and his providers, ultimately preventing another episode of homelessness.

6. Summary

The essential task of the Transition to Community phase is to facilitate clients' transition from the shelter or other institutional setting, and begin linking them to services in their new communities. A multitude of practical and emotional issues arise during this period, including finding good service linkages, and helping the client to deal with the anxieties and challenges of moving into the community. The CTI case manager's skills in dealing with the difficulties inherent in this phase will be vital, as will be finding ways to access and nurture the strengths the client will be bringing to his new situation.

C. Phase Two: Try-Out

1. Assessment of Concrete Needs and Linking

This stage is devoted to testing and adjusting the systems of support that have been established in the community. The CTI case manager should pay particular attention to the five areas of intervention previously outlined, and determine how the client is faring in area applicable to him. Some areas will need to be targeted for more intensive work, especially those that have triggered a housing crisis in the past. The case manager must use her judgment about how active to be at this stage; if possible, she should step back a bit and observe how sturdy the new community links are. If the system seems to be operating smoothly, she can become less active with the client.

However, systems usually need more time to run smoothly. Most likely, problems will arise which will require mediation and resolution. In this stage, the CTI case manager can make a fuller *in vivo* needs assessment; since the basics should already be in place, she can observe where there are holes in the system, and where the client needs more or less support or services. (See "Assessment of concrete needs and linking," p.14-16).

When problems arise between the client and new community providers, the CTI case manager might schedule a meeting with all parties to try to resolve the difficulty. It is very important during this stage for the case manager to act as a liaison between the client and his group of care-providers. These new community links are still tenuous, and need to be reinforced as much as possible.

For those clients with ongoing substance abuse issues, motivational interviewing is typically reintroduced in this stage (see p. 9-13).

2. Assessment of Psychological Issues

In this phase, the CTI case manager needs to step back to see how well the client can manage new independence, and be ready to step in if need be. The goal is to allow the client to maximize his strengths and capabilities, and to be available to help in areas where the client cannot cope well on his own. While some direct, assertive intervention by the CTI team may still be necessary, the priority should be placed on strengthening the client's skills and his linkages with community-based supports. In assessing the linkages, emphasis must be placed not only on the client's ability to seek help, but also on the ability of the community resources to respond to and meet the needs of the client.

Margaret Mahler's (1972) theories of separation and individuation offer a helpful model for the psychological tasks that are particularly relevant to this stage of CTI. In fact, she describes the "practicing subphase" of separation-individuation as a time when the child experiences a "spurt in autonomous functions." This phase is characterized by exhilarating exploration of the world, alternating with periods of "low-keyedness" when the child becomes aware of the absence of the mother.

In an article by Levy (1998), the author applies developmental theories to homeless outreach. He addresses one of the key challenges of outreach and one that we see throughout the course of treatment, especially in the Try-Out phase of CTI. Levy invokes Erikson's stage of trust vs. mistrust when he writes: "How does one promote trust in the sphere of interpersonal relationships, while providing appropriate boundaries regarding dependency issues?" (p. 127).

We believe that many of our homeless clients, by virtue of their experiences of shifting caretakers and out-of home placements (Susser et al., 1991; Caton, 1994), struggle with separation-individuation and trust vs. mistrust during the transition to the community. Although the many changes experienced during this transition may threaten to destabilize a client, they also offer an opportunity for emotional growth and reparation of developmental delays. A key factor is the gradual transition CTI offers, rather than the abrupt, traumatic rejection typifying these clients' past experiences.

The CTI team, primarily the case manager, functions as a home base or "refueling station," to paraphrase Mahler's terms. So, the client can explore his new world in the comforting presence of a familiar, caring figure. The most important challenge for the case manager is to decide when to lay back and when to actively intervene. Clinical judgment is of the utmost importance in these situations, but the team, and an experienced clinical supervisor, can offer guidance.

When crises occur in treatment at this stage they can often take the form of the client expressing a simultaneous need for help and a rejection of the very things he most needs. When this dilemma is enacted in the client's behavior, housing is often jeopardized. We view this as an expression of the client's wish to return to a familiar structure at the expense of other freedoms. Thus, we see clients who seem bent on returning to shelters or the criminal justice system.

The case manager who fails to recognize the emotional conflict underlying the client's acting out easily feels angry, frustrated, and helpless. We find it helpful to recognize the parallels to the rapprochement crisis described by Mahler as "the mainspring of man's eternal struggle against both fusion and isolation." By remaining present and available (both physically and emotionally), and resisting the temptation to withdraw or jump in and take control, the CTI case manager can help facilitate the successful navigation of this trying phase of adjustment to life in the community. Here perhaps more than anywhere else, the CTI case manger functions as a therapist helping the client recognize, verbalize, and ultimately cope with his deepest anxieties.

During this Try-Out phase, then, clients might refuse treatment out of fear of further progress and independence. Conversely, the client who has made progress might "outgrow" his treatment and refuse services that feel too restrictive or paternalistic. Knowing the difference is a key clinical decision. In the former case, one would provide the opportunity to discuss the client's anxieties about moving forward, offer reassurance and perhaps greater structure in the short-term, and temporarily increase phone or direct contacts. In the latter case, one would meet with the client to formulate a new plan that would allow greater growth and independence, encourage maximizing the client's active participation in his treatment and rehabilitation, and taper down the amount of contact.

3. Assessment of Client's Strengths

During this phase, the client will need to begin to rely on community resources, and be consistent in maintaining these new relationships. For example, he might have monthly meetings with his psychiatrist. This will require organization, so the client knows the time and the date of the appointment, and how to get to the site. If the client is forgetful and has a tendency to miss appointments, he might find ways to compensate for this; for example, by putting reminder signs around his room, or asking someone to remind him. In general, important strengths during this period are the ability to access and utilize community resources, money management, and adult daily living skills. This also might be a time when clients might want to strengthen ties with friends or family, if these people might be good supports.

4. Clinical Example

The following example illustrates how the CTI case manager might serve as an advocate for the client while also stepping back to allow the client to make use of his own abilities durin g the Try-Out or Preacticing phase.

Frank is a 42-year-old man with schizophrenia who has a long history of relapses due to noncompliance. Several times in the past, he experienced episodes of homelessness after a psychiatric decompensation. During a two-year stay in the shelter, he was finally stabilized on a combination of a decanoate form of neuroleptic and an oral dose of an atypical antipsychotic medication.

Frank was able to obtain housing in a community residence with 24-hour staff support, and was doing quite well there during the first few months of his stay. Most notably, he had saved a significant amount from his monthly SSI checks in order to take a trip to Philadelphia, where his adult son lived. Recently, however, Frank had clashed with the staff about the dispersal of his money; the residence had a policy of being the payee, and Frank got his money in weekly increments. He wanted to get the entirety of his check when it came in, in order to have the necessary funds to hasten his upcoming trip.

Now, in the fifth month of CTI, Frank is becoming increasingly angry towards the staff at the residence, and has accused them of wishing to control his every move. His hygiene has started to decline, and other residents are complaining that he smells. He recently told his case manager at the residence that he does not want to continue with his medication, as he feels his taking it is a

capitulation to staff's control of him.

At a meeting with his CTI case manager and the residence's case manager, Frank complained once again about the residence's control of his money. Together, the three of them went over Frank's budgeting thus far. The CTI case manager, acting as Frank's advocate, pointed out that he has proven that he can effectively manage his money, since he has been able to save a fixed amount from every check, and asked the residence case manager if they could make a time table for when Frank might be able to take over his monthly check. The residence case manager, persuaded by the evidence, decided the time table would be unnecessary, and agreed to let Frank receive his next check all at once.

The second issue the group dealt with was the recent changes in Frank's behavior, from his angry outbursts to his skipping showers. Frank admitted that he had stopped taking his oral medication a month ago, when residence staff had been refusing to let him manage his own money, and was planning to refuse his next injection of decanoate. When the CTI case manager asked him if he had been experiencing side effects that bothered him, he admitted that he recently had two episodes of impotence with his new girlfriend. Too embarrassed to bring it up with his psychiatrist (who did not ask him about it), and too angry with the residence staff to talk to them about it, Frank decided on his own to stop his medication.

Knowing Frank's history of relapse secondary to medication refusal, his CTI case manager had noticed the incipient signs of decompensation, and was not surprised to see that Frank was in danger of reenacting this pattern. His going off the medication was both an attempt to regain his autonomy, and an attempt to solve the problem of impotence. His case manager explained to Frank that it was likely that medication changes could resolve the problem without the unnecessary risk of relapse he was taking. Since Frank now felt his autonomy was respected, because he would be allowed to manage his next check himself, he was more amenable to talking with his psychiatrist about his impotence, and giving the medication another chance. Together, Frank and his CTI case manager went over ways that he could bring it up, and what kinds of questions he might ask. Soon after this conversation, Frank was able to talk to his psychiatrist, and they came up with an alternative regimen without the side effect of impotence. Frank also was able to take his trip to

Philadelphia for a weekend, and returned to the residence feeling happy about the time he had spent with his son.

5. Discussion of Clinical Example

In this Try-Out phase, the CTI case manager was monitoring areas in which Frank might need more or less support. Frank was showing the strength of being able to set a goal for himself, and budgeting his money to be able to reach that goal. However, he was not able to communicate clearly enough with the residence staff about his goal, and approached them with hostility whenever he talked with them about releasing his money. The residence staff, put off by his anger, did not carefully evaluate his request. The CTI case manager, then, had to encourage both the client and the residence staff to accommodate to each other. This is in keeping with the philosophy of CTI: it aims to help the client adapt to his new environment, and to help the environment adapt to the client.

The second issue that the CTI case manager dealt with was Frank's stopping his medication. Noticing the nonverbal cue of not showering, and his increasingly angry outbursts, she suspected that Frank had stopped taking his medication. Rather than being critical of him when he admitted this, however, she took an empathic stance, and asked him if there was something about the medications that bothered him. In this way, she conveyed to him her understanding that there might be very good reasons why he might not want to take his medication. With this approach, Frank was able to reveal his recent impotence. The CTI case manager could then step in and help adjust another community linkage-- Frank's relationship with his new psychiatrist. By encouraging Frank to talk with his psychiatrist about his problem, and role-playing with him how he might broach the subject, the CTI case manager helped them establish a stronger therapeutic alliance, and set the stage for improved communication in the future.

6. Summary

The essential task of the Try-Out phase is assessing the client's level of functioning, and working with the client to maximize his strengths, and anticipate his vulnerabilities. To this end, the client and CTI case manager will evaluate the linkages made with community support systems, and adjust them as necessary. The CTI case manager will see how well the client can manage his new independence, and be ready to

step in, or step back, as necessary. The client might need more or less support in certain areas. For clients with substance abuse problems, motivational interviewing occurs in this stage. The main psychological task of this phase is working through separation/individuation issues-- optimally, the client will become more independent, and less reliant on CTI case management services.

D. Phase Three: Transfer of Care

1. Assessment of Concrete Needs and Linking

Since the CTI relationship will be ending in this phase, it is vital that all links to community providers are secure. Last minute fine-tunings may be needed, but ideally everything should be in place for the client's network of long-term support. During these last three months, the CTI case manager, client, and various key players should meet together to discuss the transfer of care, and go over long-term goals. These key players might include family members, a therapist or psychiatrist, or someone from the client's residence, especially if he lives in a residence with supportive services. Ideally, this discussion should take place one to two months before the end of the nine-month CTI period, to allow time to correct any snags.

2. Assessment of Psychological Needs

The most salient issue psychologically during this phase is dealing with the end of the CTI relationship. As in the Transition to Community stage, separation issues may be revived because of the upcoming termination with the CTI case manager. Depression might set in as termination evokes feelings related to past losses. Underlying feelings of anger and abandonment might fuel a treatment refusal. Clients might also be tempted to sabotage progress as a means of obtaining increased contact with the case manager. In these cases, the case manager should let the client know that she is available to witness progress, and need not only be called upon in times of trouble. For example, the case manager might let the client know she would be happy to visit him at the clubhouse he is attending, where he has recently been making friends and becoming involved in activities. She might also encourage the client to return to the shelter, to talk to shelter residents about the experience of obtaining community housing.

This stage is also a good time to review and reflect on the work that the client and case manager have done together. They might want to look at where the client was in the beginning of the intervention, where he moved to during the intervention period, and what are possibilities that lie ahead in the future. It is important that the CTI case manager convey her confidence that the client can continue to make progress and grow. The termination of the CTI relationship can then be a step in the journey to greater self-

improvement. Now that the client is stabilized, he may be able to tackle things which have been on the back burner for years. The conversation, however, should also be framed with an understanding of what are reasonable goals to set at the present time. In this context, the two should discuss the client's strengths, new skills, vulnerabilities, and the "safety net" in place should the client need it. Finally, the client and CTI case manager should talk about their relationship-- what it has meant to them, and what they have gotten out of it. A celebration might also be a nice way to mark the end of the CTI relationship.

3. Clinical Examples

This case illustrates some of the issues faced in the Transfer of Care phase.

Travis is a 22-year-old man with a diagnosis of bipolar disorder. A year ago he had a suicide attempt when he heard that he was to be evicted from the room he was renting. Already in a deep depression, Travis could not imagine finding another place to live or a way to survive, and overdosed on his Lithium. After a neighbor found him unconscious on the floor, he was hospitalized briefly, and was discharged to the care of a friend, who kicked Travis out shortly after his discharge. From there, Travis found his way into the shelter.

During the nine-month CTI period, Travis made many changes in his life-- he successfully retained housing in a community residence, and made friends there. He saw a psychiatrist once a month, and a therapist once a week. None of these linkages to community providers were made easily-- in the beginning of the CTI period Travis denied he had any psychiatric problems, and believed seeing any kind of doctor or therapist was a waste of time, or worse, would be damaging to his stability. Because the residence he lived in required that he be engaged in treatment, he reluctantly attended his meetings. Through his strong alliance with his CTI case manager, he was slowly able to engage with his treatment team in the community, and now attended all his appointments. Medication had also been a huge issue for Travis-- he refused to take Lithium because he said it reminded him of his overdose, and triggered suicidal ideation. His psychiatrist, then, prescribed another mood stabilizer that Travis agreed to take.

In the last month of CTI, Travis started to miss his meetings with his CTI case manager. Claiming

that he was busy trying to create opportunities for his music career, Travis missed two appointments in a row. Although he appeared to be functioning very well, and the residence staff said he was thriving, the CTI case manager was concerned about his avoidance of her. Suspecting that he was trying to avoid dealing with this painful loss, and that this avoidance might lead to self-destructive behavior down the road, she insisted that Travis attend their next meeting.

In this meeting, Travis described the band he was trying to put together, and all the new people he had been meeting. The CTI case manager expressed admiration that he had been able to make so many strides in so short a time. She said she wondered, though, if Travis might be trying to show her that he could make it on his own, and that she no longer mattered to him. She said that while she had no doubt that Travis could indeed make it on his own, she imagined it might be hard for him to lose her all the same. Travis admitted, then, that he "wasn't doing well" with the thought of their upcoming termination. When asked what he meant by this, he said he had been feeling very sad and wondered if he might "slide back down that hill." The CTI case manager reframed what he considered "not doing well", and said that she saw these feelings as a sign of health-- for the first time in his life, Travis was able to feel sadness over the loss of a relationship, rather than only anger and confusion. Further, she pointed out that his fears of going to back to old behaviors were normal, and that as long as he recognized that they stemmed from the difficulty of losing their relationship, he might not act on them. Travis then realized that this was the first time he ever had to chance to say goodbye to somebody in a way that was not abrupt and traumatic. Together, Travis and the case manager decided to use this as an opportunity, and for Travis especially to work on realizing that he could retain many of the good things that had come out of the relationship. In this sense, the CTI relationship would always be there for him in his heart.

The following dialogue is a compilation of many such interactions between CTI case managers (CM) and clients (C) who are in the final stages of CTI:

CM: It's hard to believe it, but we're at the end of our time working together.

C: You know it. I never thought I'd get here. My own room, a job program, and I've been clean for a 13 months (shows the CM his AA key chain).

CM: It wasn't an easy road.

C: No way. When I first met with you, I thought you were trying to keep me down. You know, control me and my money so the program would profit. That money management was the roughest part.

CM: But without it, you'd have blown it all on crack.

C: Yeah, but I couldn't see it then. I didn't trust you. But now I see you were trying to help me. Part of it was that you're a woman. All the women I ever knew just wanted to take—your money, your drugs, your manhood. When I spoke to Dr. D (the director) and Mr. G (a CM on the team), they helped me see that you were looking after me. I gave you another chance and you hung tough with me.

CM: And now it's time to move on to even bigger and better things. Are you ready?

C: Hell yeah. Well, sometimes I see myself back on the streets smoking crack. It's not pretty, but sometimes I miss the feeling.

CM: What do you do then?

C: You know, I call my sponsor, or sometimes I just walk it off. I'll walk real fast and start thinking about my kids and how I want them to have a father who's not a bum. The medications help calm me down too. And I make my meetings. One day at a time. That's what it's all about.

CM: I can't tell you how great it makes me feel to hear you say these things and see the progress you've made. I want you to have this gift as a sign of how proud we are of you.

C: (Opens the gift to reveal an address book).

CM: You'll find our address and phone number under "C" for CTI. Don't be a stranger. We expect cards on all the major holidays. Just kidding, but please drop us a line or call to let us know how you're doing. If you want to come back and talk to the men in the housing group or one of the MICA groups, you're always welcomed.

C: I might take you up on that. And here, I have something for you. (Pulls out a business card from his pocket and hands it to the CM).

CM: (Reading from the card): "Professional lover." I didn't know you started your own business. (They share a laugh together). I'll miss you, C. Good luck.

C: I'll miss you all too. But I have people around me now who support me and my sobriety. I'm ready for the next step.

4. Discussion of Clinical Example

On one level, Travis' burst of activity in the final phase of CTI looked like the culmination of a success story-- he was completing the transfer-of-care to providers in the community, and needing his CTI case manager less and less. However, given what the CTI case manager knew of his attachment to her, something seemed to be missing from the picture. Concerned that his independence was masking his feelings about separation, she set about trying to talk about this with him. Their ensuing discussion gave Travis a real opportunity-- he could now think about his feelings of sadness as an achievement, rather than as a weakness. He was also then less afraid of acknowledging all the relationship had been to him. Going over the progress of the last nine months was a way for him to acknowledge his accomplishments, as well as a way of keeping the CTI relationship alive for himself in the future, as he continued to work on the long-term goals he had set in this period.

5. Summary

The essential task of the Transfer-of-Care phase is to deal with the end of the CTI relationship, and to address the client's long-term needs. Fine-tuning in the client's system of community care may be needed, but optimally everything will be in place at this stage. It is important to bring together all the key players in

the client's treatment at this time, to discuss work accomplished and goals for the future. CTI case managers must be especially alert to dealing with client's feelings about separation, as the termination may bring up painful past losses. One of the ways that the CTI intervention can be effective is in allowing a very different type of separation-- one that is planned for and dealt with, both practically and emotionally.

VI. HOW TO START A CTI PROGRAM

A. Introduction

CTI has been shown to be effective in a NYC shelter population (Susser et al., 1997), but may be applied to severely mentally ill patients who are facing any number of transitions. For example, CTI programs could be established for mentally ill clients living on the street, serving time in the criminal justice system, or residing in a state psychiatric hospital. The following guidelines should be used when starting a CTI program in any setting.

B. Establishing a Home Base

The fundamental principle of CTI is the provision of comprehensive services that are continuous during a transition from street or institutional settings to housing in the community. In order to do this, a home base must be established where the preparatory work leading to housing can be done as efficiently as possible. The home base must include access to psychiatric services, medical care, and the CTI case manager. A drop in center, shelter, prison mental health unit, or inpatient unit could serve as a home base for a CTI program. The most effective base of operations for a CTI program would be located on-site wherever homeless mentally ill individuals are temporarily residing.

Staff must be familiar with available housing for the homeless mentally ill. Ideally, a housing case manager would be part of the CTI team, which would also include a psychiatrist, nurse, and case managers.

The atmosphere of a home base will vary depending on the setting. However, our experience tells us that a low-demand, non-confrontational approach that is centered on the clients' perceived needs obtains the best results. The optimal setting for establishing an alliance with homeless mentally ill clients has been likened to the "holding environment" described in the writings of D.W. Winnicott (Winnicott, 1971; Felix, 1997). Initial outreach efforts are aimed at joining the client in the pursuit of need satisfaction, from the client's perspective. Thus, obtaining benefits and housing often takes priority over prescribing medication

in the early phase of treatment. Furthermore, an atmosphere of safety must be created in which patients can express their feelings, feel understood, and perceive the staff as advocates. A daily community meeting is an ideal way of establishing these aims. Most importantly, staff must be trained and given ongoing supervision in this approach.

Once a client demonstrates trust in the staff through increased attendance or requests for services, new goals and greater expectations can be introduced. The path from homelessness to housing readiness is rarely linear, and staff must be prepared for setbacks in the form of treatment refusals, substance abuse relapses, behavioral acting out, and symptom relapses. After establishing an alliance with the client, the goals of the pre-housing phase of treatment should be the procurement of benefits, development of money management skills, psychiatric stabilization, education about psychiatric illness and treatment, development of ADL and social skills, increased motivation for substance abuse rehabilitation, and placement into housing.

C. Identifying Areas of Clinical Intervention

Based on a careful assessment of the needs of the target population, areas of clinical focus should be identified that are considered critical for maintaining stability in housing. For example, the original CTI program targeted men with schizophrenia, so medication and treatment compliance was a priority. For homeless women with young children, psychological and legal counseling for battered women and services for the children might be a priority. Any program serving homeless individuals must focus on money management since payment of rent is a bottom line issue for retaining housing.

D. Establishing community linkages

While CTI is an assertive, comprehensive, team treatment approach in the early period of transition to housing, the approach demands that community linkages be established throughout the intervention. In keeping with the areas of intervention, linkages are made with housing providers, treatment providers, rehabilitative programs (clubhouses, vocational rehabilitation, educational services), family, clergy, consumer advocates, peers, and anyone in the community who could help the client achieve stability in housing and an improved quality of life. It is important that the CTI program have access to an array of linkages so that services can be tailored to the individual's needs. Thus, clients demonstrating a capacity for relative self-sufficiency might be linked to work opportunities, self-help groups, and private treatment, whereas a client with greater needs might be linked to an ACT team for long-term care.

The presence of the CTI case manager in the community facilitates the establishment of community linkages. However, it is vital that the CTI case manager clearly communicates the ultimate reliance on linkages and the time-limited nature of CTI. In other words, while CTI can provide direct, assertive treatment early in the transitional period, it is not meant to be a long-term intervention, like ACT.

E. Staffing and Supervision

The early work of engaging and treating homeless mentally ill individuals can be very labor intensive and emotionally demanding. For these reasons, caseloads should rarely exceed 10-12 clients per case manager. Once patients are placed into housing and followed by a CTI case manager, caseloads can increase up to 20:1. The reason for the increase is that clients are further along in their recovery and the establishment of linkages allows for less frequent contact with the client.

In the early Transition to Community phase of CTI, we have found that clients need at least one visit per week, but usually no more than three. By the third stage of CTI, Transfer of Care, much of the CTI work can be managed by phone, but face-to-face visits may still be required for any crises that overwhelmed the client and the established linkages. Furthermore, personal visits are essential to help the client navigate through the termination of CTI.

The CTI case managers are backed by a team of providers from the on-site homeless program. In addition to the CTI case managers, the team should consist of a psychiatrist, nurse, housing case manager, and team leader. The latter might be a social worker or one of the other professional members of the team. We require a bachelor's degree and at least two years of clinical experience to qualify as a CTI case manager. However, clinical experience, motivation, and personality weigh more than formal training in our assessment of job candidates. CTI case managers should be people with experience with this population, who are comfortable working in the community, and who are flexible, practical, empathic, and have good judgment.

In the original application of CTI in the Fort Washington Shelter, a weekly meeting was devoted to discuss clients preparing to enter housing. All case managers, including CTI case managers, a housing case manager, and psychiatrist attended this meeting. Immediately following, a CTI meeting was held with the same staff attending.

For clients just entering housing, the weekly CTI meeting should address the patient's needs in any of the five clinical areas of intervention (see p.7-14) that are applicable. As the client progresses, the intervention should focus on one or two areas of greatest need. The meeting should be run by a licensed mental health professional who is well acquainted with the CTI model and who is qualified to provide clinical supervision. In addition to the weekly staff meeting, formal and informal supervision should be made available to the CTI case managers.

In addition to participating in treatment planning during the weekly meetings, the CTI team members must be accessible for the provision of direct care when community-based services are not accessible. Treatment is provided without prejudice. So, if a client refuses to attend an outpatient clinic after being placed into housing, he is welcomed back to the homeless program and provided with care. However, efforts are made to address the reasons why community-based care is not being accessed, whether due to the client's anxiety about change, the sudden loss of benefits, or the treatment provider's unavailability. Only after making these efforts and giving the client several attempts at linking with community-based treatment should limits be set on the accessibility of care from the homeless program.

While the CTI case manager routinely makes community-based visits, other members of the team should do so only when absolutely necessary. Examples of this might include having the team attend a meeting with housing providers when eviction is being threatened or the psychiatrist coming to see a client in his home when he is deteriorating and refusing to attend treatment.

VII. CONCLUSION

This manual is meant to provide an overview of how to help people with mental illnesses who are transitioning from institutional to community living. Through an understanding of both the practical and emotional issues common during this vulnerable transitional time, mental health providers can make interventions that are both sensitive and effective. Perhaps most importantly, they can learn how to strike a balance between providing direct, assertive care, and helping clients to access community-based and inner resources.

In contrast to other models, like Assertive Community Treatment and NY State's Intensive Case Management Program, the Critical Time Intervention is time-limited and focuses on preventing recurrent

homelessness. The ultimate goal is to root clients to a community support network, allowing the fullest possible engagement of the client and his community. The continuity of the relationship between the case manager and client during the transition to housing is a fundamental principle behind CTI. We believe this not only serves to overcome practical obstacles encountered by mentally individuals who are homeless, but it also facilitates important steps in the psychological development of individuals who frequently have histories of shifting caretakers and out-of-home placement (Cite Susser and Caton).

CTI encompasses movement from an assertive approach in the first stage to linkage to services and support of independent living skills in the final stage. In between, there is opportunity to monitor the system and make adjustments based on near-term and long-term needs of the client. On one end of the spectrum are clients who demonstrate high degrees of independence. They are aware of their needs and access appropriate services. In cases of crisis, they have an accessible support network. The CTI caseworker can quickly move into the monitoring role of the Try-out phase, making sure that the client's skills are adequate. It may be possible to terminate prior to the end of nine months. On the other end of the spectrum are individuals who are struggling with treatment compliance and/or suffering from conditions that impede their independent living skills. In these instances, the bulk of the nine months involves the Transition to Community phase and services remain assertive. Linkage is made to other assertive programs, such as ACT, intensive supported housing programs, and intensive outpatient or partial hospitalization programs. The overall aim of a CTI program should be to efficiently use community resources and give clients enough room to maximize their independence and quality of life without neglected any important needs.

CTI has been scientifically tested in a population of men living in a NYC shelter in the early part of the 1990's. It may be that CTI is especially effective in systems that are rich in services, but often lack coordination or make access difficult. However, a program modeled after CTI has been successful in a remote rural region of Argentina, hundreds of miles from Buenos Aires, where the psychiatric hospital is situated (cite). That program utilized primary care physicians and local volunteers to provide services during the transition from the hospital to the community.

We believe the CTI model can be useful to other populations in other settings. At the time of publication of this manual, CTI is being tested with homeless families in suburban New York and homeless inpatients in a state psychiatric hospital. We also believe the model can be usefully applied to incarcerated

individuals with mental illness and/or substance abuse problems. In order to facilitate further studies of the CTI model of care, we have developed a fidelity measure that is included in the Appendix of this manual.

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